compliance with measures which may not be evidence-based and which may not reflect the quality of the lung cancer service. There is a wish for teams to be assessed less on these elements of process and more on outcomes. Measuring outcomes and comparing them between units is a longer term aim of the LUCADA audit. However, some respondents did acknowledge that peer review was an evolving process and many of the measures reflected good practice.

The results of this survey will be fed back to the National Peer Review team and hopefully the comments will inform further rounds of the peer review process, thereby engaging clinicians and ensuring that all patients with lung cancer have access to high quality services.

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Smoking cessation trial may be missing the point

The trial reported by Aveyard *et al*[1] in a recent issue of *Thorax* is a welcome illustration that primary care nurses are not being trained properly to deliver the behavioural support aspects of smoking cessation. However, the paper seems to miss this point and instead concludes that ''Primary care smoking cessation treatment should provide pharmacotherapy with sufficient support only to ensure it is used appropriately, and those in need of support should be referred to specialists''.

We know from a large body of previous work and systematic reviews (as referenced in the article) that well considered and planned behavioural support doubles the increase in quit rate for smoking cessation services. In this trial, however, there was no effect. The results therefore clearly show that the current form of nurse-delivered ''behavioural support'' is ineffective. Indeed, I am concerned that the authors even refer to what was delivered as behavioural support. There is no evidence that any established behaviour support techniques were delivered (eg, motivational assessment, elicitation and examination of barriers, use of action and coping plans, establishing self-monitoring regimes, use of established relapse prevention techniques). Simply asking nurses to conduct some extra telephone calls and visits without any specification of the content is pointless in terms of applying behavioural science. There is therefore a grave danger that trials such as this will be included in future systematic reviews as trials of behavioural support, even though the quality of the support offered was non-existent (or at least not established in any way). This kind of data may bias future reviews.

Furthermore, the lack of effectiveness of the nurses in this study does not mean that nurses cannot be trained to deliver this support (as the authors seem to suggest). It is my experience—and that of many other behavioural researchers[2 3]—that almost anyone can be trained to effectively deliver simple behavioural support techniques such as motivational interviewing, which are the same techniques commonly used in smoking cessation and have proved to be effective in the NICE and Cochrane reviews.

Yes, passing patients on to specialists would produce a much needed workstream for the hundreds of graduate health psychologists qualifying each year, but another alternative would be to train the nurses properly to do the job. This trial tells us nothing about the pragmatic effectiveness of behavioural support, as no behavioural support was apparently delivered.

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Authors' reply

As we reported, this trial took place in the UK National Health Service (NHS) Stop Smoking Service. The NHS has developed standards for training in behavioural support.[1] Stop Smoking Service coordinators oversee this training and the quality of services provided in the NHS, which may involve fidelity checks and, in the region we studied, mandatory annual update training.

Greaves emphasises psychological techniques that he states are necessary for the efficacy of behavioural support. Trials in smoking cessation do not show whether or not particular forms of behavioural intervention—such as cognitive behavioural interventions—are necessary for effect or whether one form is more effective than others.[2 3] Some components that Greaves suggests are essential—such as relapse prevention—have been shown to be ineffective.[4]

Behavioural support for smoking cessation in the UK is based on withdrawal orientated therapy.[5] This recognises that individuals come to clinical treatment services when they are highly motivated to stop but cannot do so because of nicotine dependence. The goal of therapy is to help reduce withdrawal discomfort during the first few weeks. Motivational enhancement is not usually part of treatment.[6]

Greaves assumes that by ''specialists'' we mean an army of health psychologists. We do not. The NHS provides two types of face-to-face NHS stop smoking support. One is by primary care nurses trained and monitored as we described. The other is by people who have undergone the same training but provide smoking cessation support as their main role. Frequently such specialists are nurses, but other professions are represented, although few psychologists do this work for the wage offered. The evidence from prospective evaluations is that the same kind of care provided by such specialists produces double the quit rate we saw in our study.[7] The difference in efficacy is not because of different training.

Evidence from other studies showing that behavioural support is ineffective even where high quality training was given to primary care professionals[8 9] reinforces our belief in the superiority of effectiveness of specialist over generalist support. Perhaps the other demands of the role of providing general care, or the appointment system that militates against regular support, lead to failure of trained generalists to equal the success of similarly trained specialists in smoking cessation. Until the NHS shows in independent evaluations that higher quit rates can be obtained in primary care, our advice would be for primary care professionals to refer smokers to specialist support or provide brief advice, using pharmacotherapy in both cases.

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An algorithm for referral of patients with IPF for lung transplantation

We read with interest the paper by Mackay *et al* on the use of disease progression in patients with pulmonary fibrosis as a trigger for referral for lung transplantation.[1] The authors attempt to identify the reasons why patients with idiopathic pulmonary fibrosis (IPF) have a higher mortality on the waiting list for lung transplantation than non-IPF patients. Although mortality on the waiting list is a major concern, physicians dealing with these patients face even more difficulties such as deciding which treatment to administer to a given patient: transplantation, inclusion in a clinical trial or classical treatment (corticosteroids, immunosuppressives and N-acetylcysteine). In order to tackle these questions we have developed an algorithm that deals with these key issues (fig 1).

Confronted with a patient with IPF, every physician needs to consider whether the patient would be suitable for transplantation as this is the only treatment that has been shown to have survival benefit.[2] Early referral is important to decrease mortality on the waiting list. If there are no overt contraindications such as age >65–70 years, recent untreatable malignancy or major vascular disease, the patient needs to be referred to a transplant centre.[3] If there the patient is found to be an appropriate candidate, the next question is whether the patient needs to be listed immediately. Key issues are blood group (as blood group O increases the waiting time significantly) and height and sex of the patient (as smaller female patients tend to have a longer waiting time on the list). Progression of disease is a chief determinant in this decision, as highlighted by the studies by Mackay *et al*[1] and Collard *et al*.[4] Another study[5] found that the clinical course of patients with IPF was characterised by clinical parameters such as deterioration in forced vital capacity, carbon monoxide transfer factor and alveolar–arterial oxygen gradient, worsening dyspnoea over 72 weeks, the number of hospital admissions and acute exacerbations of IPF. If the patient has rapidly progressing disease, he/she will be listed without delay or otherwise we perform a follow-up from close by. In this case it might be useful to include the patient in a clinical trial with a promising antifibrotic drug. As there is insufficient evidence for a significant effect of classical treatment in IPF, it is our opinion that, for proven IPF, the classical anti-inflammatory treatment needs to be reserved for patients not suitable for transplantation and those for whom inclusion in a clinical trial is not possible owing to non-compatibility with the inclusion and exclusion criteria of the protocols.

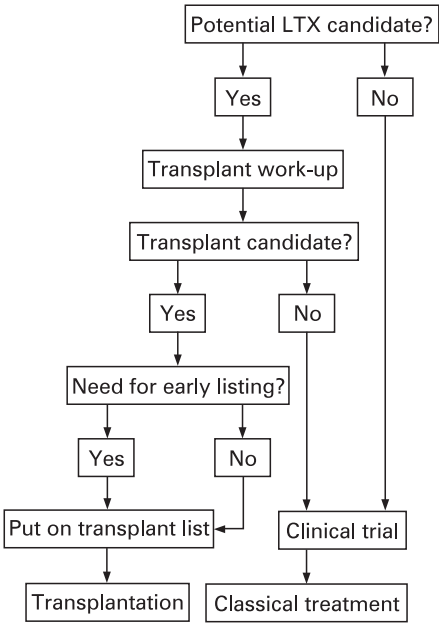

Figure 1 Algorithm for treatment of patients with idiopathic pulmonary fibrosis. LTX, lung transplantation.

In conclusion, the article by Mackay *et al* once more points to the fact that we need to choose protocols carefully to determine what to do with patients with IPF in order to provide every patient with the most effective treatment at the best possible time. We consider that this algorithm is easy but effective in dealing with these problems.

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Authors' reply

We thank Dr Wuyts *et al* for their letter and appreciate their comments on the importance of our observations. Clinicians have to make a number of difficult decisions when deciding on treatment options in patients with pulmonary fibrosis. These include whether to commence classical treatment which offers little therapeutic advantage, or whether to enter patients into a clinical trial. Importantly, in those eligible, identification of the optimal timing for referral for lung transplantation assessment is critical as this is the only treatment to be of proven benefit.

We welcome the algorithm presented by Wuyts *et al* as a simple guide for all clinicians involved in the management of patients with pulmonary fibrosis. It emphasises the pivotal role that the early identification of potential lung transplantation candidates plays, as well as considering eligibility for entry into a clinical trial. We would, however, suggest that this algorithm could be modified to allow those assessed and listed for transplantation to be considered for inclusion in such trials as a possible "bridge to transplant".

While this algorithm seems to relate to only those with idiopathic pulmonary fibrosis, we would like to suggest that it might be applied to all patients with pulmonary fibrosis. Our study highlighted that patients with pulmonary fibrosis may be misclassified on pretransplant histology and radiology or on clinical grounds, and that other forms may present with a phenotype that mimics usual interstitial pneumonia. We therefore believe that phenotype based on rate of disease progression seems to be more predictive of poor survival than histological classification or any one physiological measure.

In summary, we welcome this algorithm which challenges the conventional approach to treatment options in pulmonary fibrosis by considering first the need and suitability for transplantation and thereafter considering classical treatment or entry into a clinical trial. Such a radical change in the approach to the management may bring about considerable advances without the need for an exhaustive search for the precise histological classification.

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